MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Metroplex Diagnostics 200 Wynnewood Village Dallas, TX 75224	MDR Tracking No.: M4-04-3591-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 05 Travelers Indemnity Company	Date of Injury: Employer's Name: Genlyte Thomas Group LLC Insurance Carrier's No.: 039CBAMI5269

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/15/03	5/15/03	95904-26 x 4	38.40	38.40
5/15/03	5/15/03	95904-27 x 4	89.60	89.60
Total Amount Due				128.00

PART III: REQUESTOR'S POSITION SUMMARY

Per TWCC fee schedule, code 95904 is reimbursed per nerve. Documentation to support charges is attached.

PART IV: RESPONDENT'S POSITION SUMMARY

After careful review and consideration, this procedure code is reimbursed based on your state workers' compensation medical fee schedule this is fair and reasonable no additional due (PAYF & PAY denial codes).

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

According to the 1996 TWCC MFG, the descriptor for CPT Code 95904 allows separate reimbursement per nerve. The documentation reflects sensory nerve testing was performed on the sural and peroneal nerves in each lower extremity. The provider billed with both technical and professional and right and left modifiers. As billing is correct for the services rendered, the Requestor is entitled to additional reimbursement as indicated in the above table.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$128.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Patti Lanfranco	June 29, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____